TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
John Sklar, M.D.

Respondent Name
Travelers Indemnity Company

MFDR Tracking Number
M4-17-2770-01

Carrier's Austin Representative
Box Number 5

MFDR Date Received
May 18, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "99456 W5 WP MMI = $350.00
IR – BACK = $300.00
IR – HEAD = $150.00
IR – TEETH = $150.00
IR – DEPRESSION/ANXIETY = $150.00
TTL = $1100.00"

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "For This CPT code, the Carrier reimbursed the Provider $350.00 for the Maximum Medical Improvement evaluation per Rule 134.250(3)(C), and $600.00 for the impairment rating assignment per Rule 134.250(4)(C) and (D). Reimbursement is in accordance with the adopted Rules of the Division of Workers' Compensation, and no additional reimbursement is due for this service."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 23, 2017	Designated Doctor Examination	$150.00	$150.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.250 sets out the fee guidelines for examinations to determine maximum

medical improvement and impairment rating performed on or after September 1, 2016.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - P12 – Workers' compensation jurisdictional fee schedule adjustment.
   - 309 – The charge for this procedure exceeds the fee schedule allowance.
   - W3 – Additional payment made on appeal/reconsideration.
   - 1001 – Based on the corrected billing and/or additional information/documentation now submitted by the provider, we are recommending further payment to be made for the above noted procedure code.

Issues

Is John Sklar, M.D. entitled to additional reimbursement?

Findings

Dr. Sklar is seeking an additional reimbursement of $150.00 for an examination to determine maximum medical improvement (MMI) and impairment rating (IR) performed on February 23, 2017. Per 28 Texas Administrative Code §134.250(3), "The following applies for billing and reimbursement of an MMI evaluation… (C) An examining doctor, other than the treating doctor, shall bill using CPT Code 99456. Reimbursement shall be $350." The submitted documentation supports that Dr. Sklar performed an evaluation of maximum medical improvement. Therefore, the maximum allowable reimbursement (MAR) for this examination is $350.00.

28 Texas Administrative Code §134.250(4) states:

(C) For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas.
  (i) Musculoskeletal body areas are defined as follows:
    (I) spine and pelvis;
    (II) upper extremities and hands; and,
    (III) lower extremities (including feet).
  (ii) The MAR for musculoskeletal body areas shall be as follows.
    (I) $150 for each body area if the Diagnosis Related Estimates (DRE) method found in the AMA Guides 4th edition is used.
    (II) If full physical evaluation, with range of motion, is performed:
      (-a-) $300 for the first musculoskeletal body area; and
      (-b-) $150 for each additional musculoskeletal body area.

(D) …
  (i) Non-musculoskeletal body areas are defined as follows:
    (I) body systems;
    (II) body structures (including skin); and,
    (III) mental and behavioral disorders.
  (ii) For a complete list of body system and body structure non-musculoskeletal body areas, refer to the appropriate AMA Guides…
  (v) The MAR for the assignment of an IR in a non-musculoskeletal body area shall be $150.

Review of the submitted documentation supports that Dr. Sklar provided an IR with a full physical evaluation with range of motion for the cervical spine. Submitted documentation further supports that Dr. Sklar also provided impairment rating evaluations of the teeth, head trauma/closed head injury/closed concussive traumatic brain injury/post-concussion syndrome, and depression/anxiety. The MAR for these examinations is $750.00.

The total reimbursement allowed for the disputed services is calculated below:

Examination	AMA Chapter	§134.250 Category	Reimbursement Amount
Maximum Medical Improvement			$350.00
IR: Cervical Spine (ROM)	Musculoskeletal System	Lower Extremities	$300.00
IR: Teeth	Ear, Nose, Throat & Related Systems	Body Systems	$150.00
IR: Head Trauma	Nervous System	Body Systems	$150.00
IR: Depression/Anxiety	Mental & Behavioral Disorders	Mental & Behavioral Disorders	$150.00
Total MMI			**$350.00**
Total IR			**$750.00**
Total Exam			**$1,100.00**

The total MAR for the disputed services is $1,100.00. Traveler's Indemnity Company reimbursed $950.00. An additional reimbursement of $150.00 is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $150.00.

ORDER

Based on the submitted information, pursuant to Texas Labor Code Section 413.031 and 413.019 (if applicable), the division has determined the requestor is entitled to additional reimbursement for the disputed services. The division hereby ORDERS the respondent to remit to the requestor $150.00, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

Authorized Signature

Signature	Laurie Garnes Medical Fee Dispute Resolution Officer	June 27, 2017 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with Rule §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.